Social Impact Assessment of Luna Children's Charity Child Accelerated Trauma Therapy (CATT) training in Uganda

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Contents

1. Introduction

This report is an assessment of the impact of the work Luna Children's Charity (Luna) has undertaken in Uganda, training practitioners in a therapeutic protocol called Children's Accelerated Trauma Therapy (CATT). The report is based on a study with 15 questionnaire and 7 interview participants, who were trained in CATT between 2011 and 2015. All are Ugandan nationals. Some had been on more than one course, ie they have repeated CATT Level 2 (practitioner level) training, and some had also undertaken Level 3 training (trainer level). The research took place over a time period of November 2015 to January 2016, with the face- to-face interviews taking place in January 2016.

Luna Children's Charity (referred to as Luna throughout this report) is a registered charity that trains local mental health professionals and others working closely with child victims of trauma, together with their families and communities, to relieve the symptoms of post-traumatic stress disorder (PTSD) using CATT. CATT was devised by Carlotta Raby and has been used with children from the age of three up to adults.[1] It is a cognitive therapeutic protocol that utilises specific child-centred and play/arts based techniques, in order to help children process and re-script traumatic memories in ways that are comfortable for them and age-appropriate. This child-centred approach, and the fact that it does not rely heavily on language and/or cognitive ability of the recipient, means that it is unique and has been able to be widely accepted cross-culturally and by services supporting children with a wide range of needs. Further information and research into the effectiveness of CATT as a trauma technique may be found on Luna's website. This project was not intended as research into the effectiveness of CATT as a psychological treatment, but to evaluate the wider impact of Luna's training

[1] See Luna Children's Charity , http://lunachildren.org.uk/about-us/ [date accessed 26/05/16]

on practitioners and through them, on children, their families and communities in Uganda. This report therefore provides an insight into the outcomes of CATT training in terms of the course participants' increase in knowledge and confidence in working with children who have PTSD, their ability to psycho-educate children and their families, and based on observable and measurable positive changes in children's behaviour following a CATT intervention.

Luna's model of training enables the most advanced and experienced practitioners to gain the skills to train others to use the technique. This generates growth in the skills and knowledge needed to manage and treat PTSD, and ensures the sustainability of the work. Because people who are not mental health practitioners may use CATT, it is believed to be possible to address the suffering of children in parts of the world where mental health services are non-existent or under-resourced.

Luna has provided CATT training in Rwanda, Uganda, South Africa, Tanzania and Malaysia, and with those supporting children in the Syrian refugee camps in Turkey, Jordan and Lebanon. At the commencement of this project, Luna had been working longer and more consistently in Uganda than in any other country. Courses had been held over a period of four years, with 45 trained practitioners and 10 local trainers by the end of 2015. Uganda was therefore selected as the most suitable country in which to undertake a social impact assessment.

Luna's model of training practitioners to train others has the aim of creating a sustainable and ultimately self-sufficient system of service provision, without the need for further 'outside' support. In commissioning this assessment, Luna wished to explore how far this aim had been achieved in Uganda. Furthermore, Luna will use the findings to shape its training approach in the Middle East, where there is overwhelming need for accessible PTSD treatment among child refugees.

2. Aims and objectives

The aims of this impact assessment is to find out how effective Luna's CATT training has been in providing practitioners with the knowledge, skills and confidence needed to

- identify PTSD in children,
- treat children appropriately,
- explain the symptoms and experience of trauma to children and their families and communities in ways that change their behaviour and attitudes.

More specifically, the objectives of this assessment are to find out the answers to some key questions as follows:

- How many children have been treated, and with what outcomes?
- In what ways has CATT training changed the way that practitioners work with children?
- As a result of the training, do practitioners feel more confident in their understanding of PTSD?
- Do practitioners feel more comfortable about working with children who have PTSD?
- Have practitioners been successful in educating children, their families and communities about PTSD?
- Are families and communities now more accepting of PTSD in children, and in what ways this has been manifested?

In answering these questions, Luna expected a set of recommendations to emerge, that would guide the development of its model of training in the future. The report is also intended to provide evidence for funders who may wish to invest in Luna's training, and support its charitable activity.

3. Methodology

In November 2015, all 45 trained Ugandan practitioners were asked by e-mail to complete an online survey (Appendix 1), to which 15 responded. In January 2016 the lead researcher (co-author Sapphire Allard) travelled to Uganda for 10 days, where she was able to both observe a level two training course, and interview 7 trained practitioners. 5 of those interviewed had completed the questionnaire, but 2 had not. 4 people were interviewed at Butabika Hospital, 2 elsewhere in Kampala and 1 in the northern town of Lira.

The questionnaire produced some key statistics (see appendices 1 and 2) about the numbers of children treated, whether or not participants' confidence had increased in working with children and identifying PTSD. It also allowed participants to provide some narrative on the particulars of their experience. An initial analysis of the questionnaire responses enabled the design of a semi-structured interview questionnaire for use in Uganda.

The interview participants offered a wide spectrum of experiences. They were working in a range of different locations and positions, as psychiatric clinical officers, occupational therapists, and psychologists, in both clinical and academic roles in both Government and religious institutions. They were also an equal part male and female, from across the age range, from mid-twenties to early sixties. They had attended courses in different locations across Uganda, and across the years from 2012 to 2015. So they were not presenting opinions on only a particular course or leader, but the CATT training as a whole. 7 face-to-face interviews conducted were 45 minutes to an hour in length and allowed participants to elaborate further on the answers given in the questionnaire, as well as the chance to talk about anything else they felt important for Luna to take into consideration. This report therefore includes some issues and concerns which were not the subject of specific questions within the original questionnaire.

4. Limitations of the assessment

Whilst every effort was taken to achieve a fully representative and accurate assessment of Luna's work, there are some methodological limitations that should be acknowledged.

- The fairly small sample size, caused by lack of internet access in parts of Uganda, and the geographical isolation of some participants could have limited the variety of opinions expressed.
- Those most enthusiastic about CATT will have been most receptive to interviews and completing questionnaires, which introduces some level of bias. However, attempts were taken to limit this by explaining in a preliminary email that constructive or critical comments were equally beneficial to the research. The natural tendency for Ugandans is to be very polite so some interviewees required probing to offer constructive feedback, and the conversations were eventually thorough and candid.
- Although English is the official language of Uganda, it a second language for many and it is largely the most educated who speak it well. Thus those who came forward to be interviewed may have been those who felt most confident in their ability to express themselves in English. However, pains were taken to choose those from different professions and areas of the country, and there were some interviewees who did not appear to be entirely confident or skilled in English. In these cases, there may have been linguistic misunderstandings at points which could have affected the data, but again this was rectified as much as possible by taking the time to clarify the meanings of statements during the interview process.
- Whilst many changes to the lives of children and their families have been reported by CATT practitioners, these are not direct or independent observations made by the research team. This assessment is based on what practitioners think and have observed about the impact of their training. It provides Luna with an indication of the scope and nature of further research that may be required to reach more robust conclusions about impact.

5. Analysis

The analysis has been divided into four parts.

- Section 1 discusses the child-centred, rights-based approach and assesses the extent to which practitioners have changed their practice since training in CATT.
- Section 2 assesses the extent to which the training has increased practitioners' ability to understand and explain PTSD to children and their families and/or communities, and the impact that this has had.
- Section 3 discusses the observable and measurable outcomes practitioners have seen in children since using CATT, and the impact this has had on their families and communities around them. It also provides a brief overview of the participants' experience of using the CRIES 8 scale to measure changes in symptoms.
- Section 4 provides some indication about to which the CATT course is culturally sensitive and appropriate to working within Uganda.

5.1 Impact on practice of a child-centred, rights-based approach

A central feature of CATT training is its emphasis on equipping practitioners to work with children in a way that is fully child-centred, and supports children's rights as stated under the UN Convention of the Rights of the Child, and the African Charter on the Welfare and Rights of the Child.[2] CATT utilises specific child-centred and play/arts based techniques, in order to help children process and re-script traumatic memories in ways that are comfortable for them and age appropriate.

[2] The United Nations Convention on the Rights of the Child, http://www.unicef.org.uk/Documents/Publication-pdfs/UNCRC_PRESS200910web.pdf [date accessed 16/05/2016]/ The African Charter of the Rights and Welfare of the Child , http://www.unicef.org/esaro/African_Charter_articles_in_full.pdf [date accessed 16/05 /2016]

This section discusses this child-centred approach and evaluate the extent that CATT has helped practitioners use these new techniques since training in CATT. It answers the following questions:

- In what ways has CATT training changed the way that practitioners work with children?
- Do practitioners feel more comfortable about working and building a rapport with children since training in CATT and what particular techniques have helped them?
- What part does learning about children's rights play in working in a child-centred manner?

All 15 of the questionnaire participants stated that the training helped them work in a more child-centred way. One of the main ways that the CATT training aims to influence the way that practitioners work with children is by building their confidence in their ability to build a rapport with a child and get 'down to their level'. Luna emphasizes that it is equally important to a child's recovery for him or her to feel a sense of trust and safety with the therapist as it is for the therapist to have the scientific knowledge about the brain's reaction to PTSD. In undertaking this assessment it became apparent that this was a sentiment overwhelmingly shared by CATT participants, and equally that this aspect had been overlooked in previous training courses that they had attended. As one participant summed up:

One thing I've liked is that it is specifically designed for children, and that it creates that rapport between the therapist and the child. Because without that rapport you can't do anything. At first it is difficult to develop but then later it is really strong.

One participant interviewed said how the training:

Helped me a lot. It helped me understand children, because before doing CATT I was doing [another] training and I was arguing with them a lot because I didn't understand working with children. I didn't quite understand the dynamics (…) With CATT I learnt how to really focus on the child.

There are several practical ways that CATT encourages its participants to build this rapport and develop a sense of safety. The first step of the protocol is to ensure a comfortable setting for the child. Whilst being a simple step, in fact participants explained that simplicity means that it is something that would be often previously been overlooked and thus having this as a formal step in the process ensures its importance is respected.

One participant explained:
Something that I never paid attention to before is the environment and the comfortable setting for the child. With other therapies you may have a playroom and immediately think that it is comfortable for the child, but here we want feedback from the child 'are you safe where you are?' 'Do you want someone else to be in the room'?

Similarly, when asked to list the most useful things learnt on CATT training, another participant wrote:
I learnt that safety is very important for the child who has PTSD- this gives the child freedom to express himself.

14 out of 15 questionnaire respondents described their confidence with children as having increased *'a lot'* since training in CATT. When asked what in particular had increased their confidence, many referred to the play-based methods learned on the course. CATT's '*play approach*' (or '*play aspects'* or *'play therapy')*[3] was consistently mentioned as one of the top three most helpful skills learned on the CATT training, because it builds rapport with the child. One participant noted that *'most especially the play part of it'* had increased his confidence, because it did not rely on language. He said:

[3] This term was used by some participants - the author recognizes that play therapy is an official therapy in its own right which is not taught formally as part of CATT training

I was doing trauma work before, but I found the challenge working with children is that children don't have the language…the CATT technique makes it easy to work with a child.

Another participant explained:
CATT gives me an approach that I find really good for working with children. Handling a child in a play fashion, you don't struggle a lot with building a rapport. I remember before I had CATT, my first time I tried to work with a child that had been defiled, it took us a lot of time to build that therapeutic relationship. These days I find it easier. As long as you come in with the play attitude.

Another participant echoed this sentiment, stating simply:
CATT teaches you how to engage with the child, you can sit down and engage through the play

Many of the participants had never been taught these skills on previous training courses. Those that had noted that CATT training had two unique features:

- It is practical – participants are requested to practice play-based skills on each other during the course, and are observed and given feedback on the way that they build this rapport with children. Participants noted this was markedly different from previous courses they attended, where play was only talked about in theoretical terms.
- It teaches the use of materials to help the children tell their stories. On each CATT course, the trainers bring along a selection of local, natural materials such as sticks, grass, wool etc. and give the participants time to experiment making these figures.

As one participant explained:

I did another course on play therapy but they were complaining we don't have toys…but CATT taught us to work within your means, with what you have. You don't have to have bought toys, you can make toys from flowers, from sticks, from fibres. And these are good skills.

Another participant described how the play skills had a significant impact on her ability to build a therapeutic relationship with a particularly challenging child, enabling him to tell his story at last, and the marked change that occurred in this boy after finding this way of expressing himself. She said:
Later on he wanted to tell stories and would go up to the medical personnel and say 'can I tell you another story?' - he wanted to talk about it, and the more he talked about it the happier he was.

Practitioners were aware that in Uganda, children often are not naturally used to being asked their opinion, or to being treated equally. One participant pointed out that he had learned that it is important that children *'must feel very comfortable with you, rather than maybe suddenly they see you as a doctor, someone who is bigger than them'.*

Participants said that learning about children's rights made them understand the difference between working with children and working with adults, whilst respecting their equal rights. This was something that some, but not all, participants had learnt about in previous trainings, but not in a practical manner or that was child-specific, as one interviewee commented:
Yeah we learnt about human rights and African Charter, but there is learning and there is practice. Generally we learn but we don't put into practice. But I've learnt from children and I've learnt from CATT that it is very important to practice. To help a child to grow, to be balanced, we need to use an approach that is child-centred.

Another participant explained:

In Africa, in our culture we decide for a child everything. But a child is a human being and she has the right to be listened to, to express her own feelings. So when I work with a child, I have to listen to the child. She may tell me, I don't like this, I don't like that, and I have to respect that. I have learnt that she has the right to be listened to and express herself.

5.2 Confidence in treating and explaining PTSD, and using a systemic approach

This section will evaluate the extent that participants have increased their ability to understand and explain PTSD to children and their families and/ or communities, and the impact that this has had. This section will address the following questions:

- As a result of the training, do practitioners feel more confident in their understanding of PTSD?
- Have they been successful in educating children, their families and communities about PTSD?
- What is the advantage of using a 'systemic' approach and how practical is it to put into place?

The CATT course gives an accessible overview of the way the brain reacts when facing trauma. They are observed in small groups role-playing how they would explain this process in a way that is understandable to a child. Thus the CATT course equips participants with the ability to psycho-educate children and their families about this disorder, de-stigmatise and normalise it, and provide reassurance about recovery. The first essential part of the psycho-education process is for practitioners to feel confident themselves in their understanding of PTSD and its physical and emotional effects on the child. Although participants were already trained mental health practitioners, many did not have a good understanding of the brain or the impact of trauma

All 15 respondents to the questionnaire said that they had a better understanding of the way the brain reacts to trauma from doing the CATT course. One interviewee said that CATT training:
did a lot to help us understand the brain…it helped me understand what took place in the brain and why people have these images or sounds or problems.

Many of the participants said that cultural understanding of mental illness in Uganda can be limited and often families believe that that their child's PTSD symptoms are a sign of being bewitched. This is turn can lead to the child's being subjected to further trauma, as many told of children being physically harmed in attempts to rid of them of demons.

One participant explained how whilst she herself already had an understanding of mental illness, she did not have the terms or confidence to explain to parents in a way that made sense to them, describing how:
Some children are brought and their parents say 'my child is bewitched'. I had not learnt that psycho education, about that part of the brain and the way it works. So I could find it challenging to explain to someone 'it is not witchcraft, it is this'. However 'after having had that psycho education and I know that part of the brain I could explain to somebody 'ok the child is behaving like this not because he is bewitched but because of this part of the brain'. The other time, I could just wonder. But now I can psycho educate, I am confident.'

Similar practical-based understanding was expressed by other participants, one who explained that:
At times I could not understand why sometimes children behave not very good. But CATT has helped me to understand (…) the attitude I have towards children who are stubborn is different. Like I would punish them if they were

stubborn but now I understand the stubbornness might be that they are going through something in their lives.

All 15 of the questionnaire respondents said the training gave them new and helpful methods of explaining PTSD to children. 14 out of 15 said they have had the opportunity to use these methods with children and that they have been effective. When questioned about the particular methods that helped them to explain PTSD to children, many participants spoke of using analogies- some of which they had been directly taught on the course, the most common being giving the example of a cupboard to explain the brain's reaction to trauma.

One interviewed talked me through how he uses this analogy when working with children:
In the training one of things we learnt about talking to children about PTSD is to give an analogy of a cupboard. …If we are just throwing things into a cupboard, what will happen when we open it? Things will just fall out. So during a traumatic event, these events that you witnessed are so, so intense that the brain finds it hard to process them and store them properly

Other participants explained how they used this same analogy, whilst others described with enthusiasm how they had been inspired to make up their own analogies, and how they used them to engage the children's imagination and understanding. One participant described the analogies used with the children as also being useful with their parents, and felt that in the majority of cases 'the parents will begin to understand the reason that (they are) bringing this child', and the importance in particular of talking through the trauma in order to process the event.

Explaining PTSD to families of the children was reported to have had positive results, with 13 out of 15 of questionnaire respondents describing CATT as 'definitely' giving them new and helpful methods of explaining PTSD to

families and 14 saying that they have used these methods and that they have been effective. However, some reticence was expressed, with 6 out of 15 describing them as 'mostly' rather than 'definitely' positive. When discussing these experiences in more depth, it came apparent that there were more challenges faced when explaining PTSD to family members than there were with their children, and that these were practical, emotional and cultural.

As one participant explained: *the thing is, you have little contact with the parents. Because they have to go to work, they have to go to this…so sometimes they will sit there for maybe twenty minutes and then they rush off to work.*

The parents may understand, but be unable to follow up or support the child afterwards. One participant said: *It's easy to psycho-educate the parents because they understand what the child is going through, but then who takes responsibility for the child? You know taking care of a child is not easy. You have to take care of their accommodation, and here with our financial issues, someone cannot dedicate her life completely to do those kinds of things.*

In many cases, the care-givers also need care and treatment for trauma. One participant said:
You may talk about the children-what about the parents? Everybody is abducted and everybody feels vulnerable. The mother feels like she has a problem, the uncle says he has a problem. Everybody feels like they have a problem.

Analysis of the interviews highlights the extent of the trauma in many of the places where CATT practitioners work. CATT emphasizes the importance of families and communities in a child's recovery, but they cannot aid this recovery if they themselves are traumatized and not receiving help. As one participant reiterated: *when we pick only the child, it becomes hard because the child goes back to a traumatized family.*

Thus although the CATT protocol is designed for children, the psycho-education skills learnt during the course can, and have been used to help the families, which in turn helps the child:

So what you do is first educate the parents, counsel the parents. And when you have counselled the parents, it's easy to penetrate to the child because they know what they're going through. But if you counsel a child and then the child goes back to the same household where they do not understand. So that's why you have to psycho-educate every person who comes in contact with the child.

As well as psycho-educating parents, Luna advocates the use of a systemic approach to therapy. This means helping a child through work with the whole of a child's network: family, social workers, teachers and community members to support recovery. Some, but not all of the participants had some previous understanding of systemic work. However, most had not had the chance to put it into practice prior to using CATT. In addition, many had previously thought of systemic work as being limited to working with families, and welcomed the opportunity to extend this out to other members of the community. For example, when asked whether he had heard of a systemic approach previously, one interviewee answered:

Yeah, but not quite because a systemic approach before was just thinking about the family members, not going beyond the family members. For example the school ……. has come out to be as important as the family.

Widening out the network of support is an approach that other participants were enthusiastic about, particularly because it allowed children to have greater choice as to who supported them. One explained:

What I like about the multi systemic[4] way is that it doesn't necessarily have to be the parent. It can be the teacher, it can be the coach, it can be someone

[4] Participants frequently used the term 'multi-systemic' rather than 'systemic'. They had been taught about multi-systemic therapy in their wider mental health training, not as part of CATT

outside the child's home'….in trauma focused CBT you talk about conjoined sessions, you talk about parenting, which only means the parent. But there can be contexts where the person who is causing the problems is actually the parent- it's the parent beating the child. So then you have a conjoint session with the parent, and you have the perpetrator in the session with the child. But in CATT you give the child the chance to choose who they want to be with, so the child can say 'ok I want to be with my teacher'.

Many participants had positive experiences to share about using a systemic approach, one interviewee explaining that:
What I connected when I learnt CATT is that this child needs the system to help them, I can't work alone. That's why I will see the social worker, the teachers, so if I get information from different people, because also I have discovered that if the people in the system are cooperative then it helps faster, the healing takes place faster.

Similarly, another participant explained the benefits he had experienced of working with a child's school; *'they provide useful information'*, and in particular the benefits a child will gain if the teacher is informed and educated about the child's symptoms:
You (also) provide useful information for the school so they can understand the child, because sometimes some of the teachers think the child is uncooperative, the child maybe doesn't want school (…) but once you explain then they start to understand and even give more attention to this particular child so that they can help him out of this situation.

Another participant identified using a network as being '*very significant in the treatment of the child'*, pinpointing a particular case where '*the child moved from withdrawing to socializing because of this support system*'. One participant succinctly summed up why a systemic approach makes so much practical sense:

When children leave hospital, leave the premises of their psychotherapist, they have to go to school, so the school has to be involved, then they go home and the parents have to be involved. Then if there is a community centre where they can play then their peers will be involved, so we all contribute in assisting with different challenges a child may be facing.

However, whilst all participants were in agreement that using a systemic philosophy is best practice when possible, there are impracticalities faced in many circumstances. This is because of the social and geographical context of Uganda, where resources are limited. In many cases this means that children are treated far away from their schools and families, and as one participant explained, the system can be '*very helpful but very difficult to actually use'*, explaining that *'at times it's very difficult for you to meet with all that multi-disciplinary team. So it's not practical.'*

Another participant emphasized that these challenges were partly '*a lack of resources'* but equally that educational and cultural aspects have a part to play. In particular, when working with children whose PTSD is a result of, or is being exacerbated by, emotional abuse at home, many interviewees said that this was often disregarded. As one participant explained:
What works faster is if you alert the police-if the abuse is severe then they are coming. But the police mostly respond to physical abuse. Not emotional, emotional is not taken seriously.

This practitioner said that whilst *'psychologically you know it* (emotional abuse) *creates a big damage'*, figures in authority, such as police, will often dismiss it because it is what they have experienced themselves: '*they say 'oh we were also abused as a child it's not a bad thing'.* This is also applicable to physical abuse, which although taken more seriously by the police, is still often disregarded by parents, again on the basis that they too were hit or beaten as children, and that it is a normal form of discipline. It is in these

cases where psycho-education becomes a crucial and helpful tool in changing behaviour. One practitioner explained that:
under some circumstances you really see that the child is being abused by the parent but ……just sit down with the parent and convince them that the way they were parented, was not the best way…when you do this it will have an impact on the child's future…I try to explain that, and then many people say 'ok, I thought I was doing the right thing'.

In circumstances where this does not work, then educating parents on children's rights is fundamental, because as one participant summed up:
that's where you find their rights are violated, where there is ignorance'

CATT's right-based approach therefore also impacts on systemic work. One participant felt strongly about working closely with both children and their families, and teaching human rights both to children and parents *'side by side…because the children have to know their rights and the parents also have to know the rights of their children'*. This practitioner herself had learnt about human rights for the first time on the CATT training, and now runs a counselling centre for children where she uses CATT. She also stays in contact with the children and their families in the long-term, running events and educational classes for the children, in which an integral part is empowering the children by teaching them their rights, in particular their right to education.

5.3 Measurable and observable outcomes of using CATT with children, and the CRIES-scale

This section will focus on the following questions:

- What observable and measurable outcomes have practitioners seen in children due to CATT?

- What positive impact has this had on their families and communities around them?
- Have practitioners made good use of the CRIES-8 scale?

13 out of 15 questionnaire respondents said that they were 'definitely' able to observe and measure positive changes in the children as a result of their CATT treatment. Participants were asked on the questionnaire to name what these changes had been, rather than selecting from a list of options, and this produced a long list of detailed, qualitative responses. The main measurable changes (by the CRIES 8 score) are: a drop in anxiety or hyper-arousal symptoms, the ability to go back or to concentrate at school or work again, the ability to talk about their experiences without becoming distressed or closing up, the ability to re-visit the place or trigger of the trauma, and the ability to sleep or a reduction of nightmares.

All of these changes impact not only on the child's mental and physical wellbeing in their day to day lives but also on their futures: being able to go back to school gives them a better chance of financial stability later in life, and the ability to talk about their experiences will improve their coping mechanisms in dealing with future problems. These improvements also have a positive impact on their parents and families.

The most commonly reported change was improvement in socializing, which included going out to school or work and talking to others about the traumatic incident. The second most commonly reported change was the reduction or elimination of clinical symptoms such as nightmares and/or difficulty in sleeping. 7 respondents identified poor sleep as a symptom that had greatly improved since CATT treatment. As one interviewee commented: *Most of the trauma affects the family. Because if somebody is screaming in the night, people are not going to sleep'*

He went on to describe the living arrangements for his clients, many of who are refugees:

Refugees, their setting is a bit tricky. You find six people in one room, that's how they sleep. Now if someone is screaming in the night, they all wake up. Some of them actually have suffered traumas themselves and then someone starts screaming in the night and then their traumas start to come back. You find that the whole family is now disorganized.

Several interviewees were positive about how CATT treatment had reduced the need for medication in many cases of children with PTSD. One told the story of a teenage boy with whom she used CATT who, unexpectedly '*could go home without any medication and it was very amazing for the grandmother'*.

Similarly, another practitioner said his opinion of talking therapies had changed as a result of the CATT training:

Before CATT, I was like, without medicine it (recovery) can't happen, that was how I perceived it. (…) But doing CATT myself made me realise that without medicine things can change. That even without medicine, symptoms can go and suddenly somebody can function very well.

In particular, interviewees noted how talking about the children's problems allowed family members to open up and process their own traumatic experiences. As one practitioner noted, *'when you help that one child, you're helping all of their family'*, giving the example of one particular child he worked with:

He witnessed the attack of the family in Congo, but now the people who were directly affected by the torture were the parents. But the parents have tried to numb themselves…it is hurting them, they are traumatized but they are…now the child gets the symptoms. So when the child came along, they

also benefited. They came to realize that this is also something that they have to open up and talk about.

The CATT training teaches participants how to use the Children and War Foundation's CRIES 8 questionnaire[5] to measure the severity and change in a child's PTSD symptoms at the beginning and the end of treatment. This is an evidence-based tool that is used by many organizations working with children all over the world. 10 out of 15 questionnaire respondents described learning about CRIES 8 as being 'very helpful', 12 participants said they used the CRIES 8 'a lot' to help them identify the severity of PTSD symptoms in children. 5 participants named the CRIES 8 score as one of their top three most useful items of learning on the CATT training.

The main advantage of the CRIES 8 score is that it is a quick and simple way of gaining a clear overview of a child's PTSD symptoms. This was a sentiment expressed by one particular participant who explained that he had used another tool for measuring a child's PTSD score, but that this particular method, although effective, was too long to be practical in many cases. He explained that this was both because children get bored half way through the assessment, and there is not enough time, with the many patients that he has to see in a day. He noted that CRIES 8 was an easier method to train other front line staff in, which he had done in cases there were few medical staff, and CRIES 8 has only the eight questions. When asked whether CRIES 8 was still as effective for being so short he was confident that it was, saying '*once you get the score and then do the analysis it clearly brings out the picture*'.

Learning to use CRIES-8 had enabled CATT practitioners to measure the outcome of treatment more accurately, and enabled them to expressed confidence about the success of their CATT intervention.

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[5] Child and War Foundation 'Children's Revised Impact of Event Scale' http://www.childrenandwar.org/measures/children%E2%80%99s-revised-impact-of-event-scale-8-%E2%80%93-cries-8/ [date accessed 24/05/16]

5.4 Cultural aspects of CATT training

This section assesses the extent to which the CATT course is culturally sensitive and appropriate to working within Uganda, based on the comments of participants.

According to the Child and War Foundation, 'post traumatic stress symptoms in children are more similar than they are different from one culture to the other.'[6] The CATT technique is based on neuroscience and universally applicable, but the way it is taught has to be adapted to different cultural contexts. The cultural awareness of the CATT trainers and the protocol as a whole was a topic that all participants were questioned about. Just over half (8) of interviewees described the course as being 'mostly' culturally sensitive, with 5 describing it as 'definitely'.

Following further questioning, reservations expressed about this aspect of the course largely boiled down to a single issue. This was the re-scripting stage of the protocol, in which children identify an imaginary figure that changes their story in some way. The course uses examples such as superman and other superhero characters, which participants pointed out were targeted at children in the developed world, who are more likely to have regular access to films and television. This could be amended by simply changing the examples to characters that are familiar to Ugandan children. Additionally some participants said that Ugandan children often found it hard to picture an imaginary character. Participants said this may be because of this lack of exposure to media, and also because this is generally not as much a part of their normal day-to-day lives as it may be for children in the west.

[6] Child and War Foundation 'Children's Revised Impact of Event Scale' http://www.childrenandwar.org/measures/children%E2%80%99s-revised-impact-of-event-scale-8-%E2%80%93-cries-8/ [date accessed 24/05/16]

This is not to say that the imaginary character does not work in a Ugandan context- all participants agreed that it did, but that they themselves had to be creative in ways of adapting it to make sense for the child. Some participants reported that this could be drawing on real things rather than characters, such as natural landscapes or wild animals, all which Ugandan children may think of as powerful or strong. Overwhelmingly, therapists reported using religious figures such as Mother Mary, Jesus or an angel. One participant indicated that using religious figures had been discouraged in a particular training due to the idea that it may make a child become upset that Jesus, for example, had not protected them during their traumatic experience. The recommendation shared by participants was that there be greater time put by during the training to discuss this issue and share best practice, and also that Ugandan trainers were naturally more aware of what would work with Ugandan children than trainers from the UK. This reinforces the Luna model of development so that all CATT courses are run by local trainers. The most recent course in January 2016 was jointly run by three Ugandan therapists.

Another cultural issue in relation to the systemic approach is that it may often not work as well as in the UK due to much lower levels of resources.
One participant commented that 'the practical part of it is hard', continuing by describing delays in the criminal justice system:
For example, the times when CATT may not be able to work, when you may not be able to practice CATT is when the child is going to Court, if you already had a session with the child and then maybe the child is called to court as a witness or something. The case can take four years. So you have to wait four years, or you just have to give up the case.

Luna is clearly not able to change the context in which many Ugandan therapists have to practice, but allowing more time to acknowledge and discuss these challenges, and particularly time for therapists to brainstorm ideas themselves was noted as something that participants would have found very beneficial.

However, other participants expressed how impressed they were at the cultural appropriateness of the protocol, with one in particular commenting on the suggestion that children may keep the figures that they create to help them:

When I went and sat and thought of the concept of CATT it's like the traditional healers in Africa …what they do with patients with PTSD and those ones who have mental illness, they say before you go to sleep go and put them (herbs) under your bed. So for me its like she got the concept of traditional healers for CATT. Because in this country when someone has been hurt or in a war and so on, we talk to the traditional healers, you know without this herb that she has put under her bed she can't sleep. So imagine that is the imaginary character, that's how I took it. And it has helped.

6. Summary of findings and conclusion

Whilst all participants offered suggestions for improvement, the overwhelming consensus was that the CATT training had given them:

- Knowledge: namely psycho-education, children's rights and the CRIES 8 score which had either been entirely new or greatly improved on
- Skills: in play therapy and the therapeutic protocol itself, as well as putting knowledge into practice
- Confidence: in developing a working relationship with children and educating families, and in the outcomes of treatment

The following is a summary of findings from this assessment:

- All practitioners who responded to the questionnaire (15) have used CATT with at least one child, but the majority have treated more than 6 cases each
- Learning to use a play-based approach has made a significant impact on clinical practice.
- As a result of the training, practitioners feel more confident in their understanding of PTSD
- Practitioners have had success in educating children about PTSD
- Practitioners have been successful in educating families and communities about PTSD, but there are many practical obstacles that can constrain this task
- Psycho-education has been found to help families and communities expand their understanding and acceptance of PTSD
- The systemic approach was new learning for many but not all participants. Participants who had learnt about the approach in previous training said that the CATT course put this theoretical learning into a practical setting
- The systemic approach to therapy has been found to improve the child's healing process

- The systemic approach has been experienced as helping those within the child's life as well as the child him/herself
- In Uganda there are often financial, cultural and emotional barriers to implementing a systemic approach
- Participants of the CATT training have learnt how to use the CRIES 8 score, which they have found a helpful practical tool for assessing the symptoms of PTSD and the outcomes of treatment
- Participants of the CATT training said that learning about children's rights was often a new learning, which they had valued and had changed their practice
- Practitioners have seen measurable and significant changes in children's behaviour following CATT treatment

In conclusion, this assessment provides evidence from mental health practitioners that CATT is being used effectively in Uganda to treat children with PTSD, that it has changed attitudes and practice, and is highly valued as an intervention that works. All of the participants questioned had gone on to treat children using CATT following their training, a clear sign that it is a method that practitioners have faith in.

Lastly, it feels apt to share a memory of one man who had received CATT treatment and was eager to speak of the change that CATT had brought to his life. He said that whilst CATT cannot eradicate the trauma that he had suffered as a child soldier it had given him tools that he does and will continue to draw on upon throughout difficult times in his life. This man is now a long term volunteer, teaching current CATT clients their human rights. It is apparent that under the right circumstances, CATT training can help to bring about wide-spreading, long term and sustainable positive change for both individuals and communities.

7. Recommendations

The following is a list of recommendations that participants have requested be taken into account when delivering future CATT trainings:

- A few participants brought up the issue of using interpreters and noted that it would be useful to discuss how to work with interpreters- where they sit, what their role is etc.
- Several participants requested that the CRIES 8 score be translated into the main African languages
- One participant suggested that levels one and two be separated and very clearly outlined what you learn in each level and what you need to prove you have learnt in order to progress to the next level. This would limit upsetting anyone who was not ready for level three.
- Two participants said they would like to learn about how to work with children with substance or alcohol addictions
- The majority of participants said the cultural differences between children from the UK and Uganda should be addressed and discussed more explicitly in the training. In particular, the examples of what could be used as the 'hero' figure should be changed from superman etc. to religious figures.
- Similarly, most participants noted that it was important to acknowledge, and discuss, the difference in the practicalities of implementing a systemic approach in Uganda compared to the UK. In particular, the effectiveness and resources provided by social services, justice system, police etc. as well as the geographical distances between where the child may be being treated and the child's community.
- One participant said they would like to learn more about child abuse and the effects
- Two participants said they would like more discussion on how to treat children that are unable to speak due to trauma
- One participant requested that the CATT training be carried out in Pader and Kitgum

- One participant said they would like to learn how to use systems similar to CRIES 8 but in contexts where formal questionnaires may not apply
- One participant would like to discuss how to learn how to control one's own emotions when working with a client; e.g. stopping tears

The above recommendations and those arising more broadly from the assessment fall into three broad categories, set out in the table below:

- Changes needed to content of training
- How Luna might broaden its work
- Where Luna should undertake further research

Changes to training content	**Luna broaden its work**	**Further research**
• Clarify definitions of terms (eg. use of word 'systemic' is problematic) • Review teaching of imaginary character – use characters or objects chosen by local children where possible • Split between levels 1 and 2, creating clarity about skills and knowledge needed to move up the levels. • Allow time for more input on how to manage dual diagnoses or specific symptoms eg mutism • Include more in training about the use of interpreters • More input to be included on maintaining practitioner wellbeing and controlling emotions	• Luna to follow up on CATT training by contacting all practitioners and monitoring activity • Explore difficulties and approaches to using CATT for children learning difficulties/other barriers to full engagement • Luna to supplement CATT training with education on play therapy, community focussed and systemic approaches, engagement with children, child centered work, psychoeducation for families and communities (to reduce mental health stigma etc.) • Provide a practitioners wellbeing course • Commission/support translation of CRIES-8 into tribal languages, or develop creative use of alternative tools	• Future research should collect quantitative data • Further research into the use and appropriateness of different imaginary characters or objects • Include literature search that generates supporting evidence for Luna's work • More research/exploration of systemic work in Uganda • Further SIA on training in Middle Eastern context • Support RCT on CATT if possible

Appendix 1 – Raw Results of Luna Survey

This section has been prepared for Luna by Alex Bates

1. Firstly, please can you tell us your name?

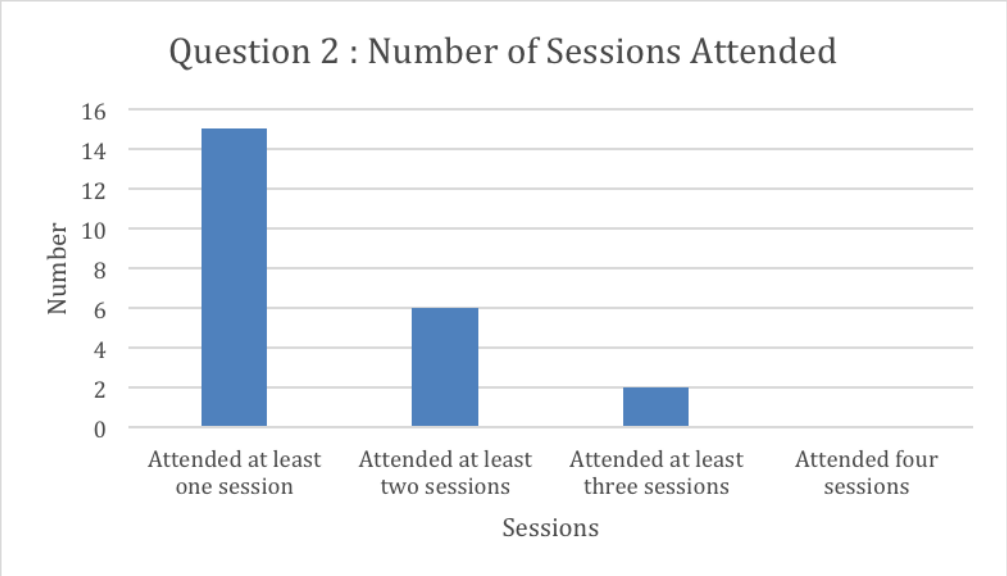
   No Analysis
2. Which of the following dates did you attend a CATT training with Luna?
   i. Session dates:

September 2013 Level 2 at PCO School, Butabika	September 2014 Level 3 at PCO School, Butabika	February 2012 Level 2 at Butabika Hospital	May-June 2014 at Arusha Mental Health Trust, Tanzania, September 2014
10	8	5	0

ii. Session count:

Attended at least one session	Attended at least two sessions	Attended at least three sessions	Attended four sessions
15	6	2	0

iii. Session count (graphic):



iv. Session content:

Level 2 highest level attended	Level 3 highest level attended
7	8

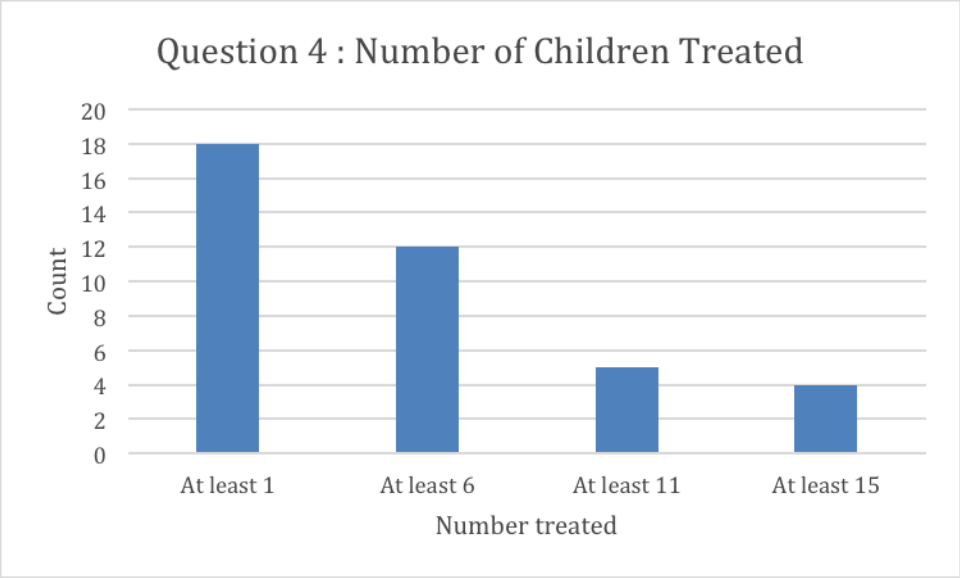
3. Since this training, have you treated any children using CATT?

Yes	No
15	0

4. If yes, how many?
   i. Treated count:

At least 1	At least 6	At least 11	At least 15
15	9	2	1

ii. Treated count (graphic):



5. Do you feel that the CATT training has increased your confidence in working with children?

Yes- a lot	Yes- a little	I'm not sure	No
14	1	0	0

6. Do you feel CATT has helped you to work in a more child- centred way?

Yes- a lot	Yes- a little	I'm not sure	No
15	0	0	0

7. Did you feel that the CATT training added to your knowledge of Children's Rights?

Yes- a lot	Yes- a little	I'm not sure	No
9	6	0	0

8. Since training in CATT, do you feel you have a better understanding of the way the brain reacts to trauma? For example , learning about things like 'fight or flight'?

Yes- a lot	Yes- a little	I'm not sure	No
15	0	0	0

9. Since training in CATT, do you feel more comfortable about helping children with PTSD?

Yes- definitely	Yes - a little	I'm not sure	No
15	0	0	0

10. Since training in CATT, do you feel more comfortable helping children reduce their PTSD symptoms?

Yes- a lot	Yes- a little	I'm not sure	No	I felt comfortable in this ability before attending the training
13	1	0	0	1

11. Since training in CATT, have you been successful in reducing the symptoms of PTSD in the children you have treated?

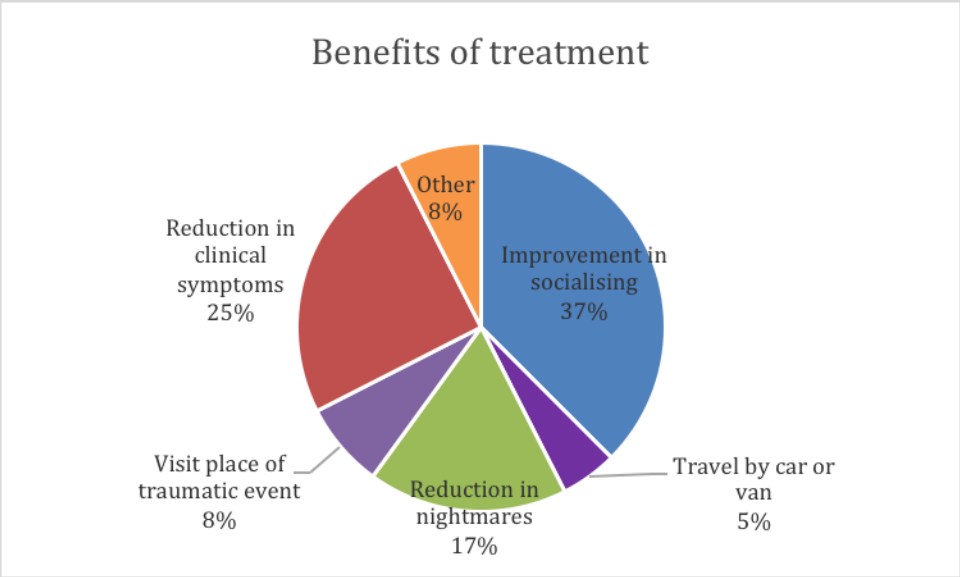
Yes- a lot	Yes- a little	I'm not sure	No
15	0	0	0

12. Are you able to observe and measure the changes in children's lives which are the result of your treatment?

Yes- definitely	Yes- a little	I'm not sure	No
13	2	0	0

13. If yes, can you give up to three examples of changes were you able to identify and measure?

Child can visit place of traumatic event (not transport like car or van)	Child can travel by car or van	Reduction in nightmares	Improvement in socialising (including school, work) / talking about incident	Reduction in clinical symptoms (for example anxiety / behavioural / PTSD symptoms)	Other
3	2	7	15	10	3



14. Did the CATT training give you new and/or helpful methods of explaining PTSD to children?

Yes- definitely	Yes - a little	No	The CATT training has not changed the way I explain PTSD to children	Other (please state)
15	0	0	0	0

15. If yes, have you had the opportunity to use these methods with children?

Yes and they have been effective	Not yet but I will do soon	No	I'm not sure when I will have an opportunity to use these methods with children
14	0	0	1

16. Did the CATT training give you new and/or helpful methods of explaining PTSD and its effects to the families of the children you work with?

Yes-definitely	Yes- a little	I'm not sure	No	Other (please state)
13	2	0	0	0

17. If yes, have you had the opportunity to use these new methods with any families yet?

Yes and they have been effective	Not yet but I will do soon	No	I'm not sure when I will have the opportunity to use these methods with families	Other (Please state)
14	0	0	1	0

18. If yes, would you describe their response as positive?

Yes- definitely	Yes- mostly	No	No response
8	6	0	1

19. How helpful to your work was learning about the CRIES 8 score?

Very helpful	Quite helpful	Not very helpful	Other (Please state)
10	5	0	0

20. Do you use the CRIES-8 questionnaire to help you identify the severity of PTSD symptoms in children?

Yes- a lot	Yes- a little	I'm not sure	No	Other (Please state)
12	3	0	0	0

21. If you do not use CRIES 8, what system do you use?

No Analysis

22. Do you feel that the CATT trainers were sensitive and aware of any differences between Ugandan and Western culture?

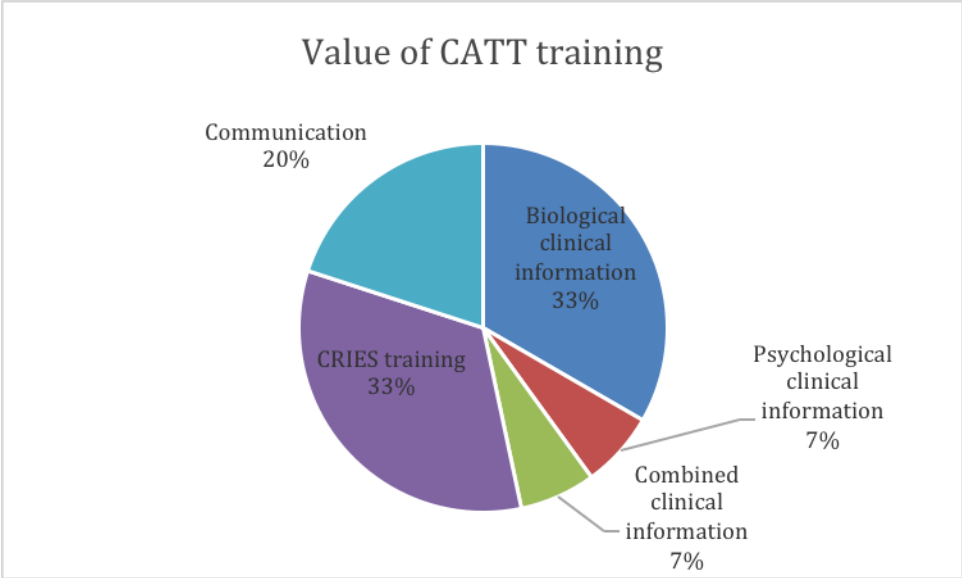
Yes- definitely	Yes- mostly	No	Other (Please state)
5	8	1	1

i. 'Other' Responses:

"To some extent they were. However to bear in mind that most Ugandan children might not be good at imagination as Western children especially when running phase two. However they need to know that U *[sic]*"

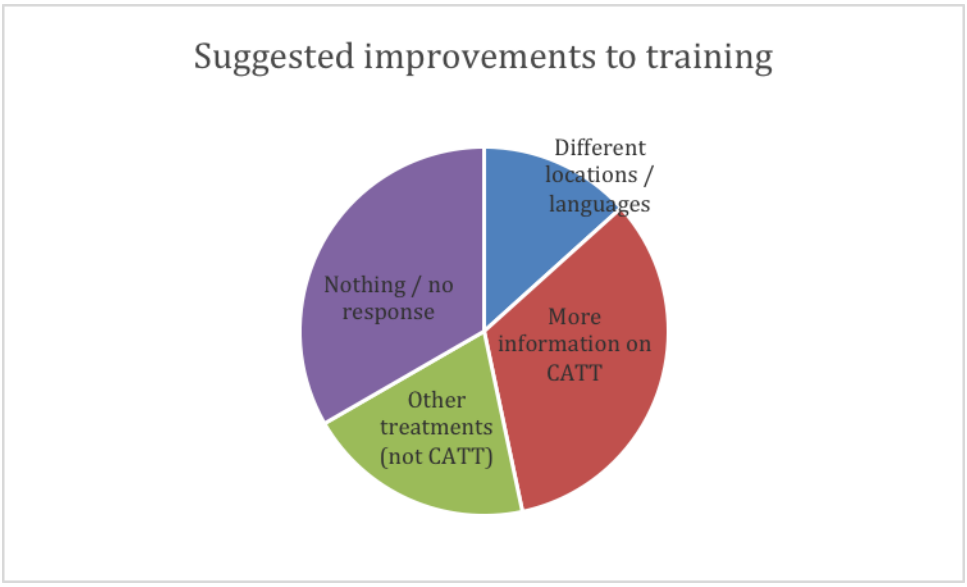
23. What are the 3 most helpful things that the CATT training has given you?

Biological clinical information (e.g. how PTSD affects the brain, role of biological components of the brain)	Psychological clinical information	Combined clinical information	CRIES training	Communication (e.g. with families or patients)	Other
6	8	10	5	7	7



24. Is there anything else that you would have liked the training to have taught you?

Different locations / languages	More information on CATT (eg treating multiple traumas)	Other treatments (not CATT)	Nothing / no response
2	5	3	5



25. Finally... we will be visiting Uganda in January to continue this research project. Would you like to be contacted for a follow- up, face to face interview?

Yes	No
15	0

CODA1: Do you feel learning about Childrens' Rights is relevant to your day- to day work with children?

Yes- a lot	Yes- a little	No
13	0	0

NB This question omitted from paper forms, so responses don't add to 15

Appendix 2 – Statistical Analysis of Question 4

Question 4 reads, 'If yes [I have treated children with CATT], how many?'. The results table is duplicated below.

Results of Question 4

At least 1	At least 6	At least 11	At least 15
15	9	2	1

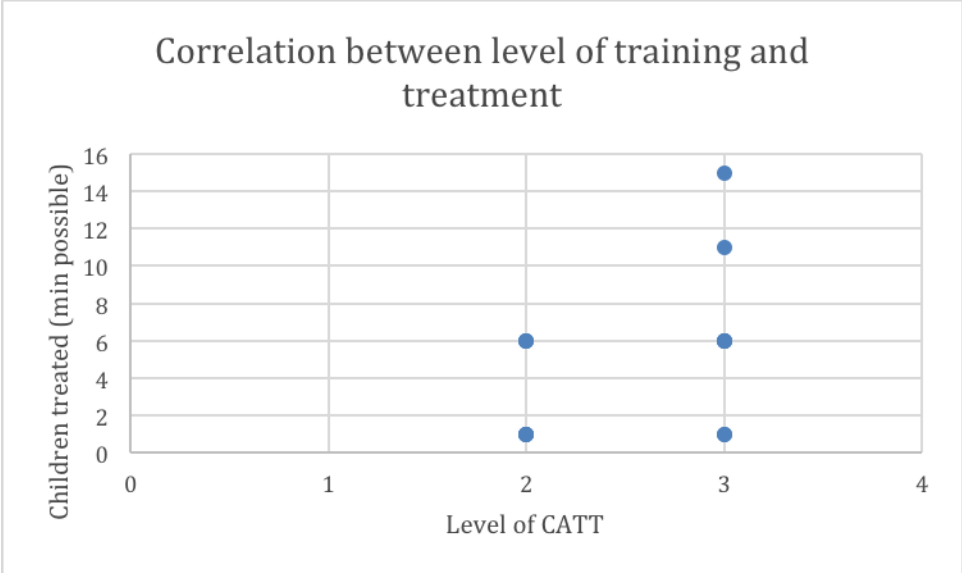
The question offers a range of numbers for participants to respond with, so it is impossible to estimate exactly how many children the average respondent has treated. It is possible to estimate a lower and upper bound (using the lower and upper bound of the ranges offered to participants). For simplicity a response of '15+' is coded as '15' in all cases.

Possible estimates of average number of children treated per respondent (raw results)

Low Estimate	Mid Estimate	High Estimate
4.9	6.8	8.7

There is some evidence of a correlation between the level of training received and the number of children treated ($r = 0.42$), but this would not usually be considered statistically significant using conventional tests ($p = 0.12$)

Scatterplot of number of children treated (minimum possible) vs highest level of training obtained



However, this relationship probably underestimates the value of a Level 3 qualification – since those practitioners with a Level 3 must have trained in Sept 2014 (vs Feb 2012 or Sept 2013 for Level 2), those practitioners have had less time to treat patients as a 'Level 3 Practitioner' relative to the time other individuals may have spent as a 'Level 2 Practitioner'. For example Participant 8 was the most prolific clinician in the survey, treating '15+'

patients, despite only being qualified in any technique at all for less than a year. By contrast, Participant 3 trained in early 2012 but has only treated '1-5' patients since then.

One method of correcting for this would be to divide the total number of patients each practitioner could have seen by the length of time they would have been practicing since their training until December 2015 (the time of the survey). Since there is a correlation between year of training and number of children treated, this substantially lowers the midpoint estimate for the average number of children treated per year, but significantly increases the estimate for the number of children treated per year by those who attended the Level 3 training

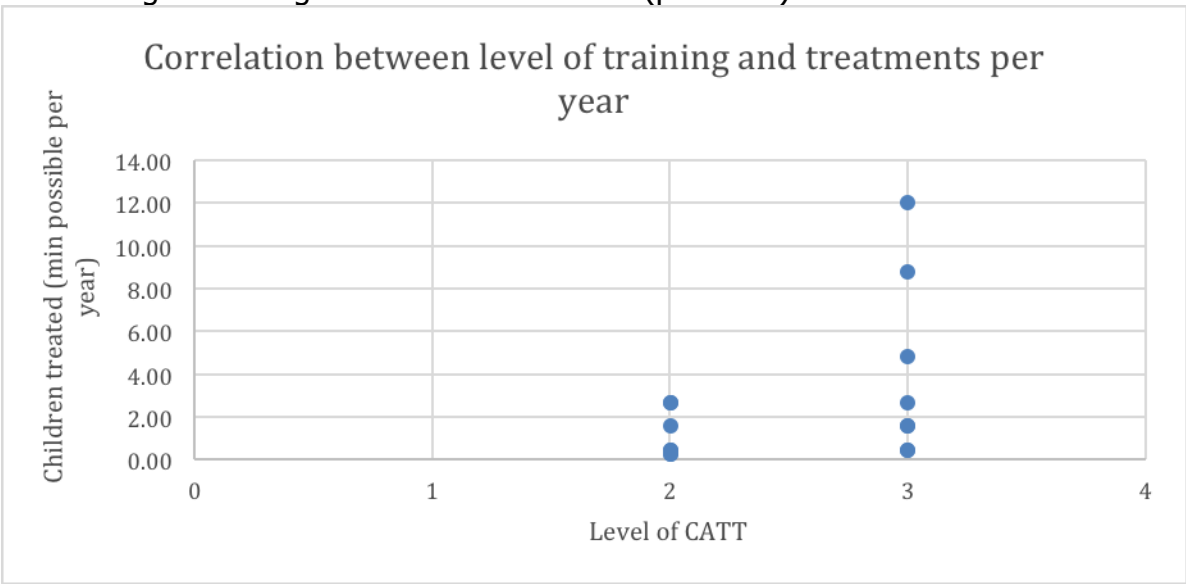
Possible estimates of average number of children treated per respondent-year

Low Estimate	Mid Estimate	High Estimate
2.7	3.5	4.3

Possible estimates of average number of children treated per respondent-year by FIRST course attended

	Low Estimate	Mid Estimate	High Estimate
2012 training (Level 2)	1.0	1.6	2.2
2013 training (Level 2)	1.4	2.3	3.4
2014 training (Level 3)	8.5	9.6	10.9

This modification does not much change the correlation between the level of training and number of children seen per year ($r = 0.42$), but makes us slightly more certain that the result is not due to chance. However it still falls short of significance given conventional tests ($p = 0.11$):



In addition, it should be considered that there are confounders that should cause us to cast doubt on the validity of this testing; most notably because there is reason to believe training is improving over time, so the results from the (latest, 2014) round of training might be made up partially of a 'better over time' effect, and partially of a 'level 3' effect; it is impossible to disaggregate this from the data.